Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EPHRAIM K BRENMAN DO
400 CONCORD PLAZA DRIVE SUITE 300
SAN ANTONIO TX 78216

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-12-0491-01

MFDR Date Received
OCTOBER 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "You denied our claim for services rendered to our patient by indicating the absence of an authorization...Dr. Brenman performed the study in good faith and it was to better evaluate and treat [Claimant]."

Amount in Dispute: $731.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3, 2010	CPT Code 95860	$117.43.00	$0.00
	CPT Code 95900 (X2)	$165.41/each	$0.00
	CPT Code 95904 (X2)	$141.39/ea	$0.00
TOTAL		$731.03	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Division rule at 28 TAC §134.203 effective March 1, 2008, sets out reimbursement guidelines for medical professional services.
3. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
4. 28 Texas Administrative Code §134.600 effective May 2, 2006 requires preauthorization for specific healthcare

and services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - 762-Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.

Issues

1. Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "762."

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   The requestor billed CPT codes 95860, 95900 and 95904 for the diagnoses 356.2-Hereditary sensory neuropathy and 726.10-Disorders of the bursae and tendons in shoulder region, unspecified.

   According to the Shoulder Chapter of the Official Disability Guidelines (ODG), nerve conduction studies are not a recommended treatment for the diagnoses 356.2 and 726.10; therefore, the disputed nerve conduction studies and EMG required preauthorization. The requestor did not submit proof that preauthorization was obtained. As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/03/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.